John Elias Baldacci
Governor

John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

October 13, 2004

TO: Interested Parties

FROM: Christine Gianopoulos, Acting Director, Bureau of Medical Services

SUBJECT: Adopted Rule: MaineCare Benefits Manual, Section 12, Chapters II & III, Consumer Directed Attendant Services

This letter gives notice of an adopted rule: MaineCare Benefits Manual, Chapters II & III, Section 12, Consumer Directed Attendant Services. This rule is adopted to implement a legislative deappropiation in MaineCare's Consumer Directed Attendant Services.

The adopted rules create service levels based on level of need as defined by specific eligibility criteria. Each level has an associated cap on the number of allowable personal care hours and a cap on the number of personal care hours that can be spent on instrumental activities of daily living (IADLs). These changes are adopted to achieve legislatively required budget savings. The adopted rules further specify the role of the provider agency. The adopted rule also clarifies when services are considered to be duplicative, covered services, definitions, and the eligibility process. Certain information, such as confidentiality requirements, that is already included in Chapter I, is deleted. Terminology, such as using MaineCare instead of Medicaid and member instead of recipient, is also updated.

Chapter III establishes new billing procedure codes based on HIPAA compliant CPT coding.

A public hearing was held on September 3, 2004. Written comments were received on the proposed rule until September 14, 2004. **This rule will be effective for services provided on or after October 31, 2004.**

Although not specifically reflected in this rule, management of this benefit has been transferred by the Maine State legislature from the Department of Labor to the Bureau of Elder and Adult Services, Department of Health and Human Services. In addition, an Independent Assessing Services Agency will be used for member assessments.

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at**://www.maine.gov/bms/MaineCareBenefitManualRules.htm** or, for a fee, interested parties may request a paper copy of rules by contacting at 207-287-9368. The TDD/TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 287-3094, or 1-800-321-5557, extension option 9 or TTY: (207)287-1828 or 1-800-423-4331 or e-mail your questions to BMS.inquiry@Maine.gov.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Bureau of Medical Services

CHAPTER NUMBER AND TITLE:
MaineCare Benefits Manual, Chapters II & III, Section 12, Consumer Directed Attendant Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The adopted rules create service levels based on level of need as defined by specific eligibility criteria. Each level has an associated cap on the number of allowable personal care hours and a cap on the number of personal care hours that can be spent on instrumental activities of daily living (IADLs). The Provider Agency will now be reimbursed for providing case management services under Section 13 Targeted Case Management of the MaineCare Benefits Manual. The Assessing Services Agency will be reimbursed through a separate contract for administrative services. Annualized aggregate state and federal expenditures will be reduced by approximately $270,000 as a result of restructuring payment for these services. These changes are adopted to achieve legislatively mandated budget savings. The adopted rules also further specify the role of the Provider Agency. The adopted rule also clarifies when services are considered to be duplicative, covered services, definitions, and the eligibility process. Certain information, such as confidentiality requirements, that is already included in Chapter I, is deleted. Terminology, such as using MaineCare instead of Medicaid and member instead of recipient, is also updated. Additional changes include revisions to billing procedure codes necessary to update MaineCare billing codes to current coding practice.

See http://www.maine.gov/bms/MaineCareBenefitManualRules.htm for rules and related rulemaking documents.

EFFECTIVE DATE: October 31, 2004

AGENCY CONTACT PERSON: Kipe Neale
AGENCY NAME: Division of Policy and Provider Services
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Me 04333-0011
TELEPHONE: (207)-287-9361 FAX: (207) 287-9369
TTY: 1-800-423-4331 or 207-287-1828 (Deaf/Hard of Hearing)

A COPY OF THE MATERIALS RELATED TO THIS CHANGE CAN BE VIEWED AT ANY DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICE.

SECTION 12 **CONSUMER DIRECTED ATTENDANT SERVICES** 5/16/95

TABLE OF CONTENTS

Page

SECTION 12 **CONSUMER DIRECTED ATTENDANT SERVICES** 5/16/95

TABLE OF CONTENTS

Page

12.01 **PURPOSE**

Effective 10-31-04

The purpose of this benefit is to provide medically necessary consumer directed attendant services for MaineCare members who are physically disabled.

12.02 **DEFINITIONS**

12.02-1 Activities of Daily Living (ADLs)**:** For the purpose of determining eligibility, ADLs include only the following:

(i) Bed Mobility: How a member moves to and from lying position, turns side to side, and positions body while in bed;
(ii) Transfer: How a member moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
(iii) Locomotion: How a member moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
(iv) Eating: How a member eats and drinks (regardless of skill);
(v) Toilet Use: How a member uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
(vi) Bathing: How a member takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
(vii) Dressing: How a member puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

12.02-2 Assessing Services Agency (ASA) is the contractor selected by the Department of Health and Human Services (DHHS or the Department) to conduct face-to-face assessments and reassessments of consumer eligibility, using the DHHS' Medical Eligibility Determination (MED) form, and the timeframes and definitions within it, to determine medical eligibility for covered services. Based upon a member's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of care that shall specify the number of hours for services. The ASA is the Department's contractor for medical eligibility determinations, care plan development, and authorization of covered services under this Section.

12.02-3 Assisted Living Services means the provision of assisted housing services, assisted housing services with the addition of medication administration, or assisted housing services with the addition of medication administration and nursing services; or supported living arrangement certified by DHHS Adult Mental Health Services. Assisted Living Services are provided by an assisted housing program, either directly by the provider or indirectly through contracts with persons, entitites, or agencies.

12.02-4 Attendant is an individual who meets the qualifications outlined by the member and Provider Agency. The attendant must be certified by the member pursuant to Section 12.07-3(C) and, under the direction of the member, must competently assist in the fulfillment of the personal assistance service needs identified in the member's authorized plan of care.

12.02 **DEFINITIONS** (cont)

Effective 10-31-04

12.02-5 Authorized Plan of Care is a plan that is determined by the ASA or the Department, and that specifies all services to be delivered to a member as allowed under this Section, including the number of hours for any MaineCare covered services under this Section. The authorized plan of care must be based upon the member's assessment outcome scores recorded in the Department's Medical Eligibility Determination (MED) form, its definitions, and the time frames on the MED form. The authorized plan of care must be completed on the Department-approved form and must not exceed services required to provide necessary assistance with activities of daily living, instrumental activities of daily living (IADL) items, and identified health maintenance activities in the MED form. All authorized, covered services provided under this Section must be listed in the care plan summary on the MED form. The authorized plan of care must reflect the needs identified by the assessment, giving consideration to the member's living arrangement, informal supports, and services provided by other public or private funding sources to insure non-duplication of services, including Medicare and MaineCare hospice services. If the member receives attendant services under this Section and he/she also receives hospice services, then the provider's responsibility is to inform the hospice provider that attendant services are being provided and the number of hours must be identified as a need on the hospice plan of care.

12.02-6 Consumer Directed Attendant Services, also known as personal care attendant (PCA) services, or attendant services, enable eligible members with disabilities to re-enter or remain in the community and to maximize their independent living opportunity at home. Consumer Directed Attendant Services include assistance with activities of daily living, instrumental activities of daily living, and health maintenance activities. The eligible member hires his/her own attendant, trains the attendant, supervises the provision of covered services, completes the necessary written documentation, and if necessary, terminates services of the attendant. The Department of Health and Human Services or the ASA, consistent with these rules, shall determine medical eligibility for services under this Section, prior authorize all covered services, and provide an authorized plan of care for each new and established member.

12.02-7 Covered Services are those services for which payment may be made by the Department under these rules pursuant to Title XIX and XXI.

12.02-8 Extensive Assistance means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days

12.02 DEFINITIONS (cont)

Effective 10-31-04

12.02-9 Family Member is a spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

12.02-10 Health Maintenance Activities are activities designed to assist the member with activities of daily living and instrumental activities of daily living, and additional activities specified in this definition. These activities are performed by a designated caregiver for a competent self-directing member who would otherwise perform the activities, if he or she were physically able to do so and enable the member to live in his or her home and community. These additional activities include, but are not limited to, catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

12.02-11 Limited Assistance is a term used to describe an individual's self-care performance in activities of daily living, as determined by the Department's approved assessment process. It means, although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was required and provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or

- Guided maneuvering of limbs or other non-weight bearing assistance three (3) or more times plus weight-bearing support one or two times.

12.02-12 Medical Eligibility Determination Form means the form, approved by the Department, for medical eligibility determinations and service authorization for the authorized plan of care based upon assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are contained therein and provide the basis for services and the plan of care authorized by the ASA. The care plan summary, contained in the MED form, documents the authorized plan of care and to avoid duplication, services provided by other possible public or private program funding sources. It also includes service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

12.02-13 Medical Eligibility Determination Packet includes a signed release of information, the completed medical eligibility determination form, the eligibility notification, hearing and appeal rights, MECARE-generated care plan that explains benefits of the authorized care plan to the member, transmittal, and contact notes. The service plan and the transmittal must be submitted to the Department by the Provider Agency once skills training has been completed and the member has hired a personal attendant. Service plans and transmittals that do not meet Department specifications and relevant policy will be returned to the Provider Agency by the Department.

12.02 DEFINITIONS (cont)

12.02-14 One-person Physical Assist requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

Effective 10-31-04

Effective 10-31-04

12.02-15 Provider/Care Management Agency (also referred to as Provider Agency) is a community-based agency meeting the Independent Living Title 7, Part C standards as defined in the Amendments to the Rehabilitation Act of 1992 as adopted by the National Council on Disabilities. The agency must have the goals of self-determination, self-help, deinstitutionalization and barrier-free access to opportunities and services. The agency must have the organizational and administrative capacity to administer and monitor consumer directed attendant services. The agency must sign a Provider/Supplier Agreement with the Department and comply with all terms of this Section, Chapter I, and other applicable Sections (e.g: Section 67) of the MaineCare Benefits Manual. The agency is responsible for a range of activities, which includes the following: coordinating and implementing the services in the member's plan of care authorized by the ASA; skills training, ensuring that authorized services are delivered according to the service plan; serving as a resource for members to identify available service options and service providers; answering questions; and assisting with resolving problems around consumer direction. The Provider Agency is also responsible for administrative functions, including maintaining member records; processing claims; overseeing and assuring compliance with policy requirements and conducting required utilization review activities. For purposes of this Section, the Provider Agency is the Department's authorized agent.

12.02-16 Qualified or Eligible Member, also called the consumer, is the member with a disability who has functional impairments that interfere with self-care and activities of daily living and meets the medical eligibility criteria in Section 12.03. The member must have the cognitive capacity, as measured on the Medical Eligibility Determination form, to competently direct and manage the attendant on the job to assist and/or perform the self-care and daily ADLS, IADLS, and health maintenance activities. The member must be determined eligible for services under this Section.

12.02-17 Self Direct means the member trains his/her attendant(s) and directs the provision of attendant services. The member's ability to self-direct must be documented on the Medical Eligibility Determination Form as defined in this Section.

12.02-18 Service Plan is the document used by the provider/case management agency to assist the member to direct his or her attendant to provide services as specified on the authorized plan of care. The service plan must outline the ADL, IADL, and health maintenance activities, the time authorized to complete the tasks, and the frequency of the tasks that will be the basis for the attendant's job description and weekly schedule. The service plan must reflect the total authorized hours available each week

12.02 **DEFINITIONS** (cont)

Effective 10-31-04

for the member to manage and direct the attendant. The hours must not exceed the hours authorized on the MED form care plan summary and must include only the covered services from Section 12.05. The service plan must not be completed until the MED form is completed, medical eligibility determined, and the number of hours of care are authorized by the ASA as allowed under this Section.

12-02-19 Significant Change means a major change in the member's status that is not self limiting, affects more than one (1) area of functional or health status, and requires a multi-disciplinary review or revision of the authorized plan of care. A significant change assessment is appropriate if there is a consistent pattern of change, with either two (2) or more areas of improvement or decline that affect member needs.

12.02-20 Total Dependence means full staff performance of the activity during the entire last seven (7) day period across all shifts.

12.03 **ELIGIBILITY FOR SERVICES**

A. Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I;

B. Applicants for services under this Section must meet the eligibility requirements as set forth in this Section and as documented on the Medical Eligibility Determination form. A member meets the medical eligibility requirements if he or she requires a combination of assistance with the required activities of daily living, as defined in Section 22.03 and as set forth elsewhere in this Section. The clinical judgment of the Department's ASA is the basis of the scores entered on the Medical Eligibility Determination form. The clinical judgment of the Department's ASA is determinative of the scores on the medical eligibility determination assessment;

C. Determination of Eligibility: A registered nurse trained in conducting assessments with the Department's approved MED form must conduct the medical eligibility assessment. The assessor must, as appropriate within the practice of professional nursing judgment, consider documentation, perform observations, and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physicians, and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment. The following levels of eligibility are determined at assessment:

12.03 **ELIGIBILITY FOR SERVICES** (cont)

Effective 10-31-04

Level I A member meets the medical eligibility requirements for Level I if he or she requires at least limited assistance plus a one person physical assist with at least two (2) of the following ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

Level II A member meets the medical eligibility requirements for Level II if he or she requires at least limited assistance and a one person physical assist with at least three (3) of the following ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

Level III A member meets the medical eligibility requirements for Level III if he or she requires at least extensive assistance and a one person physical assist with two (2) of the following five ADLs: bed mobility, transfer, locomotion, eating, or toileting and limited assistance; and a one person physical assist with two (2) of the following additional ADLS: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

D. The member must have a disability with functional impairments, which interfere with his/her own capacity to provide self-care and daily living skills without assistance. The member's disability must be permanent or chronic in nature as verified by the member's physician;

E. The member must agree to complete initial member instruction and testing within thirty (30) days of completion of the MED form to determine medical eligibility in order to develop and verify that he or she has attained the skills needed to hire, train, schedule and supervise attendants and document the provision of personal care services identified in the authorized plan of care. Members who do not complete the course of instruction or do not demonstrate to the Provider Agency that they have attained the skills needed to self direct are not eligible for services under this Section;

F. The member must not be residing in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;

G. The member must not reside in Assisted Living (as defined in MaineCare Benefits Manual (MBM), Chapters II and III, Section 6,) or in an Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2,) or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare);

12.03 **ELIGIBILITY FOR SERVICES** (cont)

Effective 10-31-04

H. The member must not be receiving personal care services under Private Duty Nursing/Personal Care Services, Section 96, or be receiving any In-home Community and Support Services for Elderly and Other Adults, Section 63.

I. The member must have the cognitive capacity, as measured on the MED form to be able to "self direct" the attendant. The ASA will assess cognitive capacity as part of each member's eligibility determination using the MED findings. The Provider Agency will assess cognitive capacity as part of consumer instruction. Minimum MED form scores are:

(a) decision making skills: a score of 0 or 1;
(b) making self understood: a score of 0, 1, or 2;
(c) ability to understand others: a score of 0, 1, or 2;
(d) self performance of managing finances: a score of 0, 1,or 2; and
(e) support for managing finances, a score of 0, 1, 2, or 3.

An applicant not meeting the specific scores above during his or her eligibility determination will be presumed not able to self direct and ineligible for benefits under this Section.

12.04 **AMOUNT AND DURATION OF SERVICES**

Each member is eligible for attendant services, as identified, documented, and authorized on the MED form, within the following limitations as described below and in Chapter III, Section 12. If the member is enrolled in a hospice and if there is any duplication between the two services as identified by the assessor and determined by the Department, certified nursing assistant/home health aide hours count toward the hourly limit and cap.

The Department or its ASA, consistent with these rules, prior authorizes the number of hours of covered services and an authorized plan of care for each new member, and for each established member, as his or her scheduled re-assessment comes due. The services provided must be reflected in the service plan and based upon the authorized covered services documented in the care plan summary of the MED form.

MaineCare coverage of services under this Section requires prior authorization from the Department or the ASA, consistent with these rules. Beginning and end dates of a member's medical eligibility period (also known as the classification period) must correspond to the beginning and end dates for MaineCare coverage for these services.

The ADL Task Time Allowances in the attached Appendix A reflect the time normally allowed to accomplish the listed tasks. The ASA will use these allowances when authorizing a member's authorized plan of care on the care plan summary in the MED form and this plan will be reflected in the service plan. If these times are not sufficient, when considered in light of a member's unique circumstances, as identified and documented by the ASA, the ASA may make an adjustment as long as authorized hours do not exceed limits established for the member's assessed level of care.

12.04 **AMOUNT AND DURATION OF SERVICES** (cont)

Effective 10-31-04

Services under this Section will be reduced, terminated, or denied by the Department, the ASA or the Provider Agency if any of the following situations occur:

A. The member exceeds the applicable Level I, II or III established caps or IADL limits.

B. The member declines these services;

C A significant change occurs in the member's medical, functional, or cognitive status and the ASA or the Provider Agency determines that appropriate services can no longer be provided under this Section;

D. The ASA or the Provider Agency determines that the health and welfare of the member is endangered should he or she remain at home receiving services under this Section;

E. The Provider Agency documents that the member fails to manage an attendant consistent with requirements of this Section;

F. The member enters a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded as an inpatient;

G. The member is receiving personal care services under Private Duty Nursing/Personal Care Services, Section 96; Home and Community-Based Benefits, Section 19; or In-home Community Support Services for Elderly and Other Adults, Section 63, HBC.

H. The member resides in assisted housing, a residential care facility, PNMI or supported living arrangement certified by DHHS Adult Mental Health (formerly DBDS) for behavioral and developmental services:

I. The member is not medically or financially eligible to receive Title XIX or XXI benefits;

J. The Provider Agency documents the member does not comply with the authorized plan of care;

K. The member gives fraudulent information to the Department, ASA or Provider Agency;

L. The Department, ASA, or the Provider Agency documents the member or someone living in or frequently visiting the household harasses, threatens, or endangers the safety of individuals delivering services;

M. The ASA or Provider Agency documents the member is directing the personal attendant to complete tasks not included as covered services in Section 12.05;

N. The member does not meet the eligibility criteria under Section 12.03; or

12.04 **AMOUNT AND DURATION OF SERVICES** (cont)

Effective 10-31-04

O. Services have been suspended for more than thirty (30) days. The member's eligibility for these services will be terminated and will require a new assessment by the ASA and prior authorization for services to restart.

Based upon the member's most recent MED assessment, the authorized plan of care shall be reduced, according to the clinical judgment of the Department, the ASA, or the Provider Agency and is subject to the limitations and caps of this Section and the approved authorized plan of care.

Suspension: Services will be suspended if the member is hospitalized, or admitted to a nursing facility or residential care. If such circumstances extend beyond thirty (30) days, eligibility under this Section shall terminate, and a new assessment by the ASA is required and prior authorization is required for services to restart.

12.05 **COVERED SERVICES**

Covered services are available for members meeting the eligibility requirements set forth in Section 12.03. All covered services require prior authorization by the Department or the ASA, consistent with these rules, and are subject to the limits in this Section. The authorized plan of care shall be based upon the member's assessment outcome scores recorded on the Department's Medical Eligibility Determination form, its definitions, the time frames therein, and the task time allowances described in Appendix A.

Members who qualify are eligible for the following Consumer Directed Attendant Services:

A. Personal Care Services (PCS). These services include services related to a member's physical requirements for assistance with the activities of daily living.

Additionally, when authorized and specified by the Department or ASA in the authorized plan of care, PCS may include IADLs and/or health maintenance activities, which are directly related to the member's plan of care. These tasks must be performed in conjunction with direct care to the member. IADLs and health maintenance activities are those activities that would otherwise be normally performed by the member if he or she were physically able to do so. It must also be established that there is no family member or other person available to assist with these tasks. Travel time only of an attendant in the course of delivering a covered service is allowed under this Section.

B. ADL tasks include assistance with:

1. Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
2. Using the toilet and maintaining continence;
3. Health maintenance activities;
4. Bathing, including transfer;
5. Personal hygiene, which may include combing hair, brushing teeth, shaving, applying makeup, washing and drying face, hands, and perineum;

12.05 **COVERED SERVICES** (cont)

Effective 10-31-04

6. Dressing;
7. Eating, and clean up and
8. Assistance with administration of medications, as directed by the member, for the member.

The ASA will use the allowances in Appendix A to determine the time necessary to complete authorized ADL tasks. If these times are not sufficient when considered in light of a member's unique circumstances as identified and documented by the ASA, the ASA may make an appropriate adjustment subject to limits and caps under this Section.

C. IADLs

1. All IADLs must be authorized and specified in the authorized plan of care. These tasks must be furnished in conjunction with direct care to the member and directed by the member. IADL tasks include assistance with:

A. grocery and prepared food shopping, assistance with obtaining medication to meet the member's health and nutritional needs;

B. routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;

C. laundry done within the residence or outside of the home at a laundry facility;

Effective 10-31-04

D. money management, as directed by the member for the member; and

E. meal preparation and clean up.

2. IADL Limits Per Level of Eligibility

A. If the member is receiving care at Level I, IADL tasks may constitute up to, but must not exceed, two (2) hours per week of authorized personal attendant services.

B. If the member is receiving care at Level II, IADL tasks may constitute up to, but must not exceed, three (3) hours per week of authorized personal attendant services.

C. If the member is receiving care at Level III, IADL tasks may constitute up to, but must not exceed, four (4) hours per week of authorized personal attendant services.

12.06 **NON-COVERED SERVICES**

Effective 10-31-04

The following services are non-covered services:

A. Room and board;

B. Travel time and mileage by the Provider Agency's staff, and/or the attendant to and from the location of the member's residence and mileage for travel by the attendant in the course of delivering a covered service;

C. Case management services;

D. Transportation to and from medical appointments is not covered under this Section and must be referred to a local MaineCare transportation agency (see Section 113 of the MaineCare Benefits Manual);

E. Household tasks except when delivered as an integral part of the authorized plan of care;

F. Services provided by the member's family member, as defined in Section 12.02-8;

G. Custodial care or respite care;

H. Personal attendant services received when a member enters a hospital, nursing facility, private non-medical institution, or Intermediate Care Facility for the Mentally Retarded as an inpatient, or any other Assisted Housing Program that is licensed to provide personal care services or when a member is receiving personal care services under Private Duty Nursing/Personal Care Services, Section 96, or is receiving any Home and Community-Based Benefits or Home Based Care services;

I. Other services described as non-covered in Chapter I of the MaineCare Benefits Manual, including vocational, recreational, custodial and educational activities.

J. Services provided by a personal attendant who has a notation on the Maine Registry of Certified Nursing Assistants of (a) any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or (b) any specific documented findings by the State survey Agency of abuse, neglect or misappropriation of property of a resident, client or patient;

K. Services provided not in the presence of the member, unless in the provision of covered IADLs;

L. On-call services;

M. Services for which the cost exceeds the limits or caps described in this Section.

12.07 POLICIES AND PROCEDURES

Effective
10-31-04

12.07-1 Eligibility Determination

A. Applicants for services under this Section must meet the eligibility requirements set forth in Section 12.03. An eligibility assessment, using the Department's approved MED assessment form, is conducted by the Department or the ASA.

These services require eligibility determination and prior authorization by the ASA.

1. If financial eligibility for MaineCare has not been determined, the applicant must be referred to the regional office of the Bureau of Family Independence, concurrent with the relevant medical eligibility determination process.

2. The Department, or its ASA conducts a medical eligibility assessment face-to-face using the Department's approved MED assessment form. The individual conducting the assessment must be a registered nurse (RN) trained in conducting assessments and developing an authorized plan of care with the Department’s approved tool. The RN assessor’s findings and scores recorded in the MED form are determinative in establishing eligibility for services and the authorized plan of care.

3. The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 12.04.

4. Applicants who meet the eligibility criteria for attendant services, as set forth in Section 12.03, and as documented by the Department's approved MED assessment form, shall:

   i. receive an authorized plan of care based upon the scores, timeframes, findings and covered services recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of care must not exceed the established financial limit and must be prior authorized by the Department or its ASA;

   ii. The assessor must approve a classification period for the member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor’s clinical judgment. An initial classification cannot exceed six (6) months and any following classification periods can not exceed twelve (12) months;

12.07 **POLICIES AND PROCEDURES** (cont)

Effective 10-31-04

iii. The assessor forwards the completed assessment packet to the Provider Agency within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care;

iv. The Provider Agency must contact the member within twenty-four (24) hours of receipt of the MED assessment and authorized plan of care. The Provider Agency must implement skills training and coordinate services with the member as well as monitor service utilization and assure compliance with this policy; and

v. The Provider Agency will complete the service plan and initial skills instruction within thirty (30) days of the medical eligibility assessment date. The Provider Agency will notify the Department, using the transmittal form approved by the Department, when the member has successfully completed this requirement and an attendant has been hired. Provision of services and reimbursement for attendant services can begin only after the Department is notified that the member has successfully completed this training and the service plan has been received.

12.07-2 Reclassification and Continued Services

For all members under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved medical eligibility period (also known as the classification period) a reassessment to determine medical eligibility and prior authorization of services by the ASA is required. MaineCare payment ends with the reassessment date, also known as the medical eligibility end date.

Step #1: The Provider Agency must submit a reassessment request to the ASA. The ASA must complete a reassessment at least five (5) calendar days prior to the end date of the member's current medical eligibility period to establish continued eligibility for MaineCare coverage of Attendant Services. If the need for additional consumer skills instruction has been identified by the ASA or the Provider Agency, it will be documented in the member's service plan.

Step #2 The individual conducting the assessment will be trained by the Department in conducting assessments and developing an authorized plan of care using the Department's Medical Eligibility Determination form. The assessor's findings and scores recorded in the MED form shall be determinative for establishing eligibility for services and the authorized plan of care. The service plan shall not be completed until medical eligibility has been determined and services authorized, as allowed under this Section, in the care plan summary of the MED form.

12.07 **POLICIES AND PROCEDURES** (cont)

Effective 10-31-04

Step #3: The ASA shall review, face-to-face with the member at the member's residence, the medical eligibility for services at least every six (6) months during the first year the member receives services under this Section and at least annually thereafter, in accordance with the member's current medical eligibility period, or sooner, if a Significant Change occurs.

12.07-3 Professional and Other Qualified Staff

The following professionals are qualified professional staff:

A. Eligibility Determination staff employed by the ASA or the Department must be a registered nurse licensed to practice nursing in the State of Maine.

B. Consumer Instruction staff are employed by the Provider/Care Management Agency and include:

1. A registered nurse licensed to practice nursing in the State of Maine;

2. An Registered Occupational Therapist who is licensed to practice occupational therapy in the State of Maine; or

3. A Certified Occupational Therapy Assistant who is licensed to practice occupational therapy in the State of Maine, under the documented supervision of a licensed occupational therapist.

C. Attendant

An attendant must be at least seventeen (17) years old and have the ability to assist with Activities of Daily Living. An attendant cannot be an individual who has a notation on the Maine Registry of Certified Nursing Assistants of (a) any criminal convictions, except for Class D and Class E convictions over ten (10) years old that did not involve as a victim of the act, a patient, client, or resident of a health care entity; or (b) any specific documented findings by the State Survey Agency of abuse, neglect or misappropriation of property of a resident, client or patient.

After the completion of consumer instruction, the member shall train the attendant on the job. Within a twenty-one (21) day probation period, the member will determine the competency of the attendant on the job. At a minimum, based upon the attendant's job performance, the member will certify competence in the following areas:

12.07 **POLICIES AND PROCEDURES** (cont)

Effective 10-31-04

- ability to follow oral or signed and written instructions and carry out tasks as directed by the member;
- disability awareness;
- use of adaptive and mobility equipment;
- transfers and mobility; and
- ability to assist with health maintenance activities.

Satisfactory performance in the areas above will result in a statement of attendant competency for each attendant. This statement must be signed by the member, submitted to the Provider Agency, and a copy kept in the member's record.

12.07-4 Member Appeals

The Department, the ASA and/or Provider Agency must notify the member in writing that he/she has the right to appeal when there has been a denial, termination, suspension or reduction of eligibility for a MaineCare covered service under this Section. In order for services to continue during the appeal process, a request for an appeal must be received by the Department within ten (10) days of the notice to reduce, deny, suspend, or terminate services. Otherwise, a member has sixty (60) days from the date of the notice in which to appeal a decision. Members shall be informed in writing by the ASA or the Provider Agency of their right to request an administrative hearing in accordance with this Section and Chapter I of the MaineCare Benefits Manual. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling 1-800-262-2232, Local 207-287-9200, or TTY: Toll Free 1-888-720-1925, or TTY: Local 207-287-9234.

Bureau of Elder and Adult Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

12.07-5 Member Records

A. The ASA must establish and maintain record for each member that includes at least:

1. The member's name, address, mailing address if different, and telephone number;
2. The name, address, and telephone number of someone to contact in an emergency;

12.07 **POLICIES AND PROCEDURES** (cont)

Effective 10-31-04

3. Complete assessments including the MED form, (maintained in MECARE for the ASA), with the care plan summary that matches needs identified by the scores and timeframes on the MED form and authorized by the ASA. All assessments and reassessments must include the date they were done and the electronic signature of the person who did them;

4. A dated release of information signed by the member that conforms with applicable state and federal law and is renewed annually.

B. The Provider Agency must establish and maintain a record for each member that includes all items in Section 12.07-5 (A) and all items included below:

1. The service plan must indicate the type of services to be provided for each covered ADL, IADL, and health maintenance activity identified in the MED form, and specify the number of hours per week, the tasks, and reasons for the service;

2. Documentation must be provided and available in the member's record of the verification by the member's physician of the chronic or permanent nature of the member's functional disability;

3. Documentation of all contacts between the member and the attendant, including date, services covered, type of contact, and duration; a daily task list of covered services is acceptable, providing it matches the authorized plan of care (Section 7 of the MED form) on the care plan summary of the MED form;

4. Documentation of the entrance and exit times for the personal care attendant and for consumer instruction staff (travel time to and from the location of the member is not covered);

5. Documentation of the results of member instruction and testing;

6. Documentation of ability to self direct, as documented on the MED form and as required in member instruction and testing;

7. Signed certification(s) of attendant competency;

8. Attendant payroll records, approved timesheets and employment forms;

9. Documentation of all complaints, by any party including resolution action taken;

10. Written progress notes that summarize any contacts made with or about the member and:

(a) The date the contact was made;

12.07 **POLICIES AND PROCEDURES** (cont)

Effective 10-31-04

(b) The name and affiliation of the person(s) contacted or discussed;

(c) Any changes needed and the reasons for the changes in the service plan; and

(d) The signature and title of the person making the note and the date the entry was made.

Member's records shall be kept current, available to the Department, and retained in conformance with Chapter I. Such records shall be documentation of services included on invoices.

12.07-6 Surveillance and Utilization Review

Requirements of Surveillance and Utilization Review are detailed in Chapter I of the MaineCare Benefits Manual.

12.08 **REIMBURSEMENT AND PROVIDER AGENCY RESPONSIBILIES**

A. Reimbursement for covered services shall be the lower of the following:

1. The amount listed in Chapter III, Section 12, "Allowances for Consumer Directed Attendant Services;"

2. The lowest amount listed by Medicare; or

3. The Provider Agency's usual and customary charge.

B. The Provider Agency's administrative responsibilities include:

1. identifying the need for additional non-scheduled reassessments or additional instruction;

2. providing member instruction and testing that meets the following criteria:

a. provision of at least four (4) hours of instruction initially in the management of personal attendants and additional instruction as needed;

b. instruction must be provided to each new eligible member prior to the start of services. The provider must document that the member has successfully completed the training within thirty (30) calendar days of the determination of medical eligibility and successfully passed a test;

c. instruction in PCA management includes: instruction in recruiting, interviewing, selecting, training, scheduling and supervising a competent attendant in the activities identified in the authorized plan of care and as necessary, terminating an attendant; and

12.08 **REIMBURSEMENT AND PROVIDER AGENCY RESPONSIBILIES** (cont)

Effective 10-31-04

d. instruction of the member in his or her rights and responsibilities, including the obligations under this Section.

3. monitoring, through face-to–face or telephone contact at least every six (6) months, documenting and taking appropriate action concerning any changes in the general health and welfare of the member;

4. assessing the member/attendant relationship, including whether attendant duties are being performed satisfactorily, whether attendant training is adequate or if additional training is needed;

5. taking appropriate action, including reporting to the Department, any evidence of public nuisance, substance abuse, harassment, neglect, exploitation, or fraud on the part of the attendant, member, member's household or visitor;

6. documenting, investigating all complaints from any party within two (2) business days and resolving all complaints within thirty (30) days;

7. establishing and maintaining member files in accordance with this Section;

8. processing claims for payment;

9. preparing information as required by the DHHS on payment for specific services and beneficiary status;

10. preparing and distributing of attendant payroll;

11. collecting member co-payments; and

12. maintaining a complaint log.

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other sources that are available for payment of the rendered services prior to billing MaineCare.

Reimbursement under this Section is subject to the unit rounding requirements and other reimbursement requirements listed in Chapter I of the MaineCare Benefits Manual.

12.09 **COPAYMENT**

Requirements regarding copayment disputes and exemptions are contained in Chapter I of the MaineCare Benefits Manual

A. A copayment will be charged to each MaineCare member receiving services, with the exception of those exempt, as specified in the MaineCare Eligibility Manual. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

12.09 **COPAYMENT** (cont)

MaineCare Payment for Services	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

Effective 10-31-04

B. The member shall be responsible for copayments up to $5.00 per month whether the copayment has been paid or not. After the $5.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

12.10 **BILLING INSTRUCTIONS**

Effective 10-31-04

Providers must bill in accordance with the Department's billing instructions for the HCFA 1500 that providers receive in their enrollment packages.

ADL = Activities of Daily Living			
Activity	**Definitions**	**Time Estimates**	**Considerations**
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes	Positioning supports, cognition, pain, disability level.
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes up to 15 minutes	Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer mechanical lift transfer.
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done during Plan of Care)	Disability level, type of aids used, pain.
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes	Supervision, disability, cognition, pain, type of clothing, type of prosthesis.
Eating	How person eats and drinks (regardless of skill)	5 minutes	Set up, cut food and place utensils.
		30 minutes	Individual is fed.
		30 minutes	Supervision of activity due to swallowing, chewing, cognition issues.
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 -15 minutes/use	Bowel, bladder program ostomy regimen, catheter regimen.
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	20 min/day	Disability level, pain, cognition, adaptive equipment.
	Washing face, hands, perineum, combing hair, shaving and brushing teeth	Shampoo (only if done separately) — 15 min up to 3 times/week Nail Care — 20 min/week	
Walking	How person walks for exercise only How person walks around own room How person walks within home How person walks outside	Document time and number of times in plan of care, and level of assistance needed.	Disability, pain, mode of ambulation (cane), prosthesis needed for walking.
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes	If shower used and shampoo done, then consider as part of activity.

Effective 10-31-04

Effective 10-31-04

These allowances reflect the time normally allowed to accomplish the listed tasks. The ASA will use these allowances when authorizing a member's authorized plan of care. If these times are not sufficient when considered in light of a member's unique circumstances as identified by the ASA, the ASA may make an adjustment as long as the authorized hours do not exceed limits established for member's level of care .

Time authorized has to reflect the possibility of concurrent performance of activities, ex: while wash cycle running, dishes may be washed, floor vacuumed, bathroom cleaned, and other simultaneous activities.

CODE #	Description	UNIT	MAXIMUM ALLOWANCE
CA22	Personal Care Attendant - Level 1*	hour	$ 9.12
CA22-TF	Personal Care Attendant –Level II *	hour	$ 9.12
CA 22 TG	Personal Care Attendant –Level III *	hour	$ 9.12
CA25	Personal Care Attendant -Level I*	half hour	$ 4.56
CA25-TF	Personal Care Attendant –Level II *	half hour	$ 4.56
CA 25-TG	Personal Care Attendant –Level III*	half hour	$ 4.56

Effective 10-31-04

Effective 10-31-04 * Effective with this rule the maximum reimbursement per member per month is Level I $ 474, Level II $ 710, and Level III $ 1105.

In the near future the HIPAA compliant procedure codes will replace the codes above. The Department will notify providers thirty (30) days in advance.

	Attendant Care Services –Level I	15 minutes	$ 2.28
	Attendant Care Services –Level II	15 minutes	$ 2.28
	Attendant are Services-Level III	15 minutes	$ 2.28